

casualties, dead and injured, of the entire Vietnam War to date. Traffic injuries, then, must be a very expensive component of the health care bill. There are many other examples of what might be called socially engendered causes of rising health care costs which should be taken into account. For example, changing social attitudes have greatly increased the number of vasectomies, hysterectomies and legal abortions which now appear on the health care bill. For another example, changing sexual mores have given rise to a rampant and as yet uncontrolled epidemic of venereal diseases whose victims require health care services. Ours is a nation of drug and medicine users, even of drug dependents, both in the straight culture and in the counter-culture, and this, aided and abetted by advertisers and the news media, contributes significantly. Very little is known about the effects of pollution, poverty, poor nutrition or cultural and educational deprivation on health care costs. The impact of overuse of alcohol is more obvious. It is irrational to hold physicians, health professionals or even the health care industry responsible for these socially engendered causes of rising health care costs or to expect them to contain them.

By tradition the health care bill also has included many custodial services which are really not health care at all. These either should not be cost-accounted to health care or else they should be clearly identified for what they are. Costly cost controls, the ever growing administrative demands by government, third party payors and others, and the necessity imposed by society for health professionals and health facilities to practice more and more defensive medicine are all increasing daily and all are adding significantly to the causes of rising health care costs. Conceivably some or many of these kinds of growing costs could be reduced through more enlightened policies and procedures on the part of government and others.

If the causes of rising health care costs are somewhat as have been outlined, as seems likely, then better cost accounting of the various components of the health care bill would seem to be an essential step which should be taken soon if any real progress in reducing these costs is to be made. Excited rhetoric, emergency measures and crisis solutions have so far accomplished very little and obviously will never suffice. Some

components of the overall health care bill can probably never be reduced, and in fact they will have to be increased if the national goals are ever to be achieved. But an objective cost accounting of health care could do much to indicate where the costs are actually coming from and where it is likely they can be reduced. For example, certain services which are traditional and widely used may not be worth the cost. This might be the case with some widely used screening procedures. Or the overall need for services might be reduced. This might be the case if more emphasis on "traffic medicine" were substantially to reduce the number and severity of traffic injuries and consequently the amount of health care rendered.

It can only be concluded that cost accounting of health care is something which is very much needed and that serious attempts should be made to do this reasonably, objectively, and soon.

—MSMW

Methadone Treatment Of Opiate Addiction

POINTING TO THE HIGH rates of rehabilitation of heroin addicts in methadone maintenance programs, Dr. Ramer in the current Medical Staff Conference printed elsewhere in these pages urges that opiate addiction be dealt with as a medical problem, rather than by criminal sanctions. It is one of the ironies of medical history that the recent success of methadone maintenance in treatment of opiate addiction required the criminal approach to addiction which preceded it. The idea of opiate maintenance for addicts is an old one. Perhaps with the awareness that some of the giants of medical history were addicted to opiates during their most productive years, many physicians have long suspected that with a regular supply of opiates of controlled dosage and composition, addicts might function in a socially normal manner. Certainly until the Harrison Act became law many physi-

cians attempted to treat addicts this way and the British approach to treatment of opiate addiction is based on this premise.

Previous attempts at opiate maintenance have failed or been flawed, as in the British case, by the difficulties in clinical practice of controlling abuse of prescribed opiates. There is no magic in methadone itself; pharmacologically it differs from other opiates in only minor, if useful, ways. The unique success of the methadone maintenance programs in the last ten years has been due to the fact that since prescriptions of opiates for the treatment of addicts was illegal, the programs were initiated under the rigid canons of clinical research on a "new" drug. The elaborate set of controls characteristic of sophisticated clinical research were the real reasons for clinical success.

As a research program we do not really need endlessly to replicate the 80 to 90 percent maintenance and rehabilitation rates now reported from a number of our centers. Yet, for both social and humanitarian reasons, we in medicine should attempt to extend this success rate to the treatment of the entire opiate dependent population of the United States. In doing this, we must not forget our mistakes of the past. This expansion must be done by organizations capable of scrupulous surveillance of both personnel and large groups of patients. Criteria of selection of patients must be coordinated to prevent shopping. The effort has to be organized to prevent addicts from entering multiple programs and to

prevent methadone supplies from appearing as a street drug. On a small scale these problems have appeared already. We are clearly describing a public health effort rather than an addition to the treatment repertoire of the solo physician.

The rigorous conditions necessary for the relative success of methadone maintenance programs immediately expose the gaps in our knowledge of opiate addiction from biochemistry to human motivation. Yet the success of methadone maintenance adds some intriguing leads. Many addicts report desiring the "flash" when they inject heroin, but they are willing to do without this in a methadone maintenance program. Street addicts seek higher and higher doses of heroin as they become tolerant of the drug, but they are willing to do without this on a methadone program. Neither the threat of punishment nor enforced abstinence has shown any effect in reducing opiate usage; yet addicts are as averse to crime and jail as anyone else, which is why they seek out methadone programs.

These new observations, along with many older ones, are pieces of a puzzle that remain to be put together. Methadone maintenance is the best we have for the chronic opiate addict now. We will have to put the puzzle together to get the real answer.

J. BARRY DECKER, M.D.
*Acting Program Chief
Community Mental Health Services
San Francisco Department of Public Health;
Assistant Clinical Professor
Department of Psychiatry
School of Medicine
University of California, San Francisco*

CYSTS AND SOLIDS BEFORE THE MENOPAUSE

In a premenopausal woman, how long may one continue to aspirate recurrent cysts?

Indefinitely, I would say. We do not aspirate cysts that are fluctuant. If you have a firm cyst and you cannot decide whether it's a cystic or a solid lesion, you should aspirate it to make the diagnosis. If it's a solid lesion, it should be operated upon promptly just as in the case of any other solid lesion suspected of being carcinoma. If it's a cyst it should only be operated upon if it reappears within the next several weeks. We follow them for two, three, and sometimes four weeks. If a firm lesion appears in that period or if the cyst aspirant is bloody, we feel that excisional surgery for biopsy purposes is essential. So we continue to do this indefinitely as long as the cysts appear and we can't differentiate them from solid lesions.

—GEORGE P. ROSEMOND, M.D., Philadelphia
Extracted from *Audio-Digest Surgery*, Vol. 18, No. 1, in the Audio-Digest Foundation's subscription series of tape-recorded programs. For subscription information: 1930 Wilshire Blvd., Suite 700, Los Angeles, Ca. 90057